Exhibit 12

Universal Health Group

PATIENT EVALUATION

Universal Health Group, Inc

Patient Name: Redacted

Date: 06-29-10

Current Complaints:

- [x] Neck Pain Type: Burning 5/10
- [x] Mid Back Pain Type: Cramping 5/10
- [x] Low Back Pain Type: Burning 10/10
- [ ] R Arm Numbness
- [x] L Arm Numbness
- [x] R Leg Numbness thigh constant
- [ ] L Leg Numbness
- [x] Upper Extremity Weakness R
- [x] Lower Extremity Weakness R L

- [x] Headaches Frequency: daily
- [ ] Dizziness Frequency:
- [ ] Memory Loss Frequency:
- [ ] Tinnitus Frequency:
- [ ] Jaw Pain Frequency:
- [ ] Memory Loss
- [x] Trouble Sleeping
- [ ] Others:

Difficulty:

- [x] Sitting
- [x] Standing
- [x] Lifting
- [x] Bending
- [x] Pushing
- [x] Pulling
- [x] Reaching Overhead
- [x] Squatting
- [x] Kneeling
- [ ] Others:

Muscle Spasm:

- [x] Sub Occipitals
- [x] Cervical Spine Para Spinal
- [x] Thoracic Spine Para Spinal
- [x] Lumbar Spine Para Spinal
- [ ] Traps
- [ ] Levator Scapula
- [x] Quadratious Lumborum
- [ ] Piriformis
- [ ] Hamstrings

Palpation Cervical:

- [ ] C1
- [ ] C2
- [ ] C3
- [ ] C4
- [ ] C5
- [ ] C6
- [ ] C7

Palpation Thoracic:

- [ ] T1
- [ ] T2
- [ ] T3
- [ ] T4
- [ ] T5
- [ ] T6
- [ ] T7
- [ ] T8
- [ ] T9
- [ ] T10
- [ ] T11
- [ ] T12

Palpation Lumbar:

- [ ] L1
- [ ] L2
- [ ] L3
- [ ] L4
- [ ] L5
- [ ] Sacrum
- [ ] Right Ileum
- [ ] Left Ileum

CERVICAL EXAM

- [x] Neck Spasms (+) N
- [x] Right
- [x] Left
- [x] Sub-Occipitals Spasm
- [ ] Decreased Grip Strength R 10
- [x] Decreased Muscle Strength R 10
- [x] Cervical Compression Test (+) - Slight
- [ ] Shoulder Depression Test (+) - Stretches
- [ ] Soto Hall Test + -
- [ ] Valsalva's Test + -
- [x] Cervical Distraction Test (+) -

ROM: Pain: 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓ ↑	PAIN
FLEXION	WNL	1
EXTENSION	↓	2-3
RIGHT LATERAL FLEXION	↓	2
LEFT LATERAL FLEXION	↓	2
RIGHT ROTATION	↓	1
LEFT ROTATION	WNL	1

Re-Evaluation continued

page 2

Lumbar Exam

- [x] Lumbar Spasms (Y) N
- [x] Right
- [x] Left
- [x] Decreased Muscle Strength (R) L
- [x] Straight Leg Raiser Right (+)
- [x] Straight Leg Raiser Left (+)
- [ ] Braggard's Test +
- [x] Kemps Test (L) (R) (+)
- [x] Patrick Faber Test (L) (R) (+)
- [ ] Other

ROM : Pain = 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓ ↑	PAIN
FLEXION	↓↓	3
EXTENSION	↓↓	3
RIGHT LATERAL FLEXION	↓↓	3
LEFT LATERAL FLEXION	↓↓	3
RIGHT ROTATION	↓	2-3
LEFT ROTATION	↓	2-3

Other

- [ ] Chest pain
- [ ] Abdominal Pain
- [ ] Head Pain
- [ ] Elbow Pain R L
- [ ] Hand Pain R L
- [ ] Leg Pain R L
- [ ] Knee Pain R L
- [ ] Ankle Pain R L
- [ ] Foot Pain R L
- [ ] Others:
- [ ] Others:

Testing / Consultations:

- [x] Medical Doctor Dr. Chandler
- [x] MRI (+) C/spine C3-C7, T11-12, (+) L/spine L3-L5
- [x] CT SCAN Hospital
- [x] EMG Radiculopathy C5-6
- [ ] CLOSED HEAD EVALUATION
- [ ] IME
- [x] PHYSICAL THERAPY 2/week
- [x] HOSPITAL Day of MVA
- [x] PAIN MANAGEMENT Dr. Pierce
- [x] Dr. Tal...
- [ ] Dr. Kornblum - treatment, no surgery until 4-6 months
- [ ]
- [ ] See Previous Re-Exam

Diagnosis:

- [x] Cervical Sprain
- [x] Thoracic Sprain
- [x] Lumbar Sprain
- [x] Headaches
- [x] Cervical Radiculitius
- [x] Lumbar Radiculitius
- [x] Muscle Spasm(s)
- [ ] Joint Pain
- [x] Cervical disc displacement
- [x] lumbar disc displacement
- [x] thoracic disc displacement
- [x] Cervicalgia
- [x] lumbago
- [x] thoracic pain
- [ ]
- [ ]

Re-Evaluation continued

Treatment Plan

☑ Continue current treatment plan 3 times a week for 4 weeks.

☑ Moist Heat
☐ Ice
☑ Mechanical Traction
☑ Deep Tissue Massage Therapy 1 week
☐ Therapeutic Exercises
☑ Adjustments

Cervical Thoracic Lumbar

Disability

☑ Work
☑ Household
☐ Attendant Care ____ times a week, for ___ hours a day
☐ Driving

Prognosis

☐ Excellent
☐ Good
☑ Guarded
☐ Poor
☑ Depend on further treatment
☑ Depend on further diagnostic testing
☐ _____

Goals

☑ Decrease Pain
☑ Increase Strength
☑ Increase Range of Motion
☑ Restore activities of daily living
☑ Initiation of Independent home exercise program
☐ Back to a full time work schedule

Discussion

1) Continue TX 3/week
2) Massage Therapy 1/week
3) PT 2/week
4) Follow up with Dr. Chuhuc, Dr Reese, Dr Kornbloom

Physicians Signature: [signature]

Date: 6-29-10

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) — OTHER: X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B130224

2. PATIENT'S NAME: Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: M X F

4. INSURED'S NAME: Redacted

5. PATIENT ADDRESS (Street, Apt. No., City, State, Zip Code, Telephone Number)

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (Street, Apt. No., City, State, Zip Code, Telephone Number)

8. PATIENT STATUS: Single Married X Other
Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO X
b. AUTO ACCIDENT? YES NO X PLACE (State)
c. OTHER ACCIDENT? YES NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH: Redacted SEX M X F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06 29 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: FRANCISCO GUTIERREZ JR BS
17a.
17b. NPI 1700041365

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 72210 72211 7231 7242 7234 7244

20. OUTSIDE LAB? YES NO X $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847 0
2. 847 1
3. 847 2
4. 722 0

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 29 10	06 29 10	11		99212		1234	150 00	1		NPI	1700041365
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 6530C3741

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 150 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
FRANCISCO GUTIERREZ
SIGNED 07 01 10 DATE

32. SERVICE FACILITY LOCATION INFORMATION
UNIVERSAL HEALTH GROUP
25900 GREENFIELD RD #140
OAK PARK MI 48237
a. 1588832653 b.

33. BILLING PROVIDER INFO & PH. # 248 8894580
UNIVERSAL HEALTH GROUP
5761 W MAPLE RD
WEST BLOOMFIELD MI 48322
a. 1588832653 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD VARIOF-16-ENV / NBCF-16-ENVSS

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Universal Health Group

PATIENT RE[...]LUATION
Universal Health Group, Inc.

22B133548

Patient Name: Redacted

Date: 05-25-10

Current Complaints:

- [x] Neck Pain Type: Shooting 7-8/10
- [x] Mid Back Pain Type: STABBING 9/10
- [x] Low Back Pain Type: Radiating 8/10
- [x] R Arm Numbness
- [x] L Arm Numbness worse = tingling in Hands
- [x] R Leg Numbness
- [x] L Leg Numbness
- [x] Upper Extremity Weakness (R) (L)
- [x] Lower Extremity Weakness (R) (L)

- [x] Headaches Frequency: DAILY in P.M. WORST
- [x] Dizziness Frequency: on / off
- [ ] Memory Loss Frequency:
- [ ] Tinnitus Frequency:
- [ ] Jaw Pain Frequency:
- [ ] Memory Loss
- [x] Trouble Sleeping
- [ ] Others: ____

Difficulty:

- [x] Sitting
- [x] Standing
- [x] Lifting
- [x] Bending
- [x] Pushing
- [x] Pulling
- [x] Reaching Overhead
- [x] Squatting
- [x] Kneeling
- [ ] Others: ____

Mid Back Pain Severe and Ribs (Fractured)

Muscle Spasm:

- [ ] Sub Occipitals
- [x] Cervical Spine Para Spinal
- [x] Thoracic Spine Para Spinal
- [x] Lumbar Spine Para Spinal
- [x] Traps
- [x] Levator Scapula
- [x] Quadratious Lumorum
- [x] Piriformis
- [x] Hamstrings

Palpation Cervical:

- [x] C1
- [x] C2
- [ ] C3
- [x] C4
- [x] C5
- [x] C6
- [x] C7

Palpation Thoracic:

- [x] T1
- [x] T2
- [ ] T3
- [x] T4
- [x] T5
- [x] T6
- [x] T7
- [x] T8
- [x] T9
- [ ] T10
- [ ] T11
- [ ] T12

Palpation Lumbar:

- [ ] L1
- [ ] L2
- [ ] L3
- [ ] L4
- [ ] L5
- [ ] Sacrum
- [ ] Right Ileum
- [ ] Left Ileum

CERVICAL EXAM:

	Y	N
[x] Neck Spasms		
[x] Right		
[x] Left		
[x] Sub Occipitals Spasm		
[x] Decreased Grip Strength	(R)	(L) WORSE
[x] Decreased Muscle Strength	(R)	(L) WORSE
[x] Cervical Compression Test	(+)	-
[x] Shoulder Depression Test	(+)	-
[ ] Soto Hall Test	+	-
[ ] Valsalva's Test	(+)	-
[x] Cervical Distraction Test	(+)	-

ROM : Pain 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓	↑	PAIN
FLEXION	✓		2-3
EXTENSION	✓		2-3
RIGHT LATERAL FLEXION	✓		2-3
LEFT LATERAL FLEXION	✓		2-3
RIGHT ROTATION	✓		2-3
LEFT ROTATION	✓		2-3

Re-Evaluation continued

Lumbar Exam

- [x] Lumbar Spasms (Y) N
- [x] Right
- [x] Left
- [x] Decreased Muscle Strength (R) (L)
- [x] Straight Leg Raiser Right (+) -
- [x] Straight Leg Raiser Left (+) -
- [x] Braggard's Test (+) -
- [x] Kemps Test (L) (R) + -
- [x] Patrick Faber Test (L) (R) + -
- [ ] Other

ROM : Pain= 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓ ↑	PAIN
FLEXION	↓	3
EXTENSION	↓	3
RIGHT LATERAL FLEXION	↓	3
LEFT LASTERAL FLEXION	↓	3
RIGHT ROTATION	↓	3
LEFT ROTATION	↓	3

Other

- [ ] Chest pain
- [ ] Abdominal Pain
- [ ] Head Pain
- [x] Elbow Pain (R) (L)
- [ ] Hand Pain R L
- [ ] Leg Pain R L
- [x] Knee Pain (R) (L)
- [x] Ankle Pain (R) (L)
- [x] Foot Pain (R) (L)
- [ ] Others: ______
- [ ] Others: ______

Testing / Consultations:

- [x] Medical Doctor DR. CHAPLER
- [x] MRI R.O.A. = Sending out for our MRI Next Visit
- [ ] CT SCAN R.O.A.
- [x] EMG Sending out Today to DR. TORIA for HA'S
- [ ] CLOSED HEAD EVALUATION
- [ ] IME
- [ ] PHYSICAL THERAPY
- [x] HOSPITAL Detroit Receiving
- [ ] PAIN MANAGEMENT
- [x] B/LAT. Knee Joint effusions
- [x] 6/7/10 Appt with Detroit Receiving
- [ ] Rt. PCL Tear
- [ ] See Previous Re-Exam

Diagnosis:

- [x] Cervical Sprain
- [x] Thoracic Sprain
- [x] Lumbar Sprain
- [x] Headaches
- [x] Cervical Radiculitius
- [x] Lumbar Radiculitius
- [x] Muscle Spasm(s)
- [x] Joint Pain B/LAT Knees, ELBOW'S, ANKLES
- [x] Both Knee Caps Broken
- [x] Lt. Sided Rib Fractures 5-6 Ribs BROKEN
- [x] Torn PCL w/ Lt. Leg
- [x] Rt. FOOT Fracture
- [x] 2nd Digit TOE Fractures Rt. Foot
- [ ]
- [ ]
- [ ]
- [ ]
- [ ]

Re-Evaluation continued

Treatment Plan

☐ Continue current treatment plan 3 times a week for 4 weeks.

☑ Moist Heat
☐ Ice
☑ Mechanical Traction
☐ Deep Tissue Massage Therapy
☐ Therapeutic Exercises Cervical Thoracic Lumbar
☑ Adjustments C/T/L

Disability

☑ Work
☑ Household
☑ Attendant Care 7 times a week, for 16 hours a day
☑ Driving

Prognosis

☐ Excellent
☐ Good
☑ Guarded
☐ Poor
☑ Depend on further treatment
☑ Depend on further diagnostic testing
☐ _____

Goals

☑ Decrease Pain
☑ Increase Strength
☑ Increase Range of Motion
☑ Restore activities of daily living
☑ Initiation of Independent home exercise program
☑ Back to a full time work schedule

Discussion

1) cont. Tx Plan
2) Follow up Dr. Chevalon, Patient Receiving Hosp., Dr Tolen, and Sending out for C/T/L MRI's Next Visit
3) Home TENS / HEP

Physicians Signature: [signature] **Date:** 5/25/10

STATE FARM INSURANCE
1500 P.O. BOX 2361
BLOOMINGTON IL 61702-2361

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) X | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B133548

2. Redacted

3. Redacted SEX: X M | F

4. Redacted

5. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

6. PATIENT STATUS: Single X | Married | Other; Employed | Full-Time Student | Part-Time Student

7. INSURED'S ADDRESS: Redacted

8. RESERVED FOR LOCAL USE

9. a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M | F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES | X NO
b. AUTO ACCIDENT? YES | X NO PLACE (State)
c. OTHER ACCIDENT? YES | X NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M | F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06 09 2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 04 20 2010

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO $ CHARGES 0

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 847 0
2. 847 1
3. 847 2
4. 728 4

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 25 10	05 25 10	11		99212		1	150.00	1		NPI	1104973007
2 05 27 10	05 27 10	11		97010	59	1	35.00	1		NPI	1104973007
3 05 27 10	05 27 10	11		98941		1 2 3 4	75.00	1		NPI	1104973007
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN | EIN: 205918486 X

26. PATIENT'S ACCOUNT NO.: 00001243

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE $ 260.00

29. AMOUNT PAID $ 0.00

30. BALANCE DUE $ 260.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
DAVID KATZ DC
SIGNED 06 09 2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION
UNIVERSAL HEALTH GROUP, INC
26561 W. 12 MILE ROAD
SOUTHFIELD MI 48034
a. 1588832653 b.

33. BILLING PROVIDER INFO & PH. # ( )
UNIVERSAL HEALTH GROUP, INC.
5761 WEST MAPLE ROAD
WEST BLOOMFIELD MI 248 626 6892
a. 1588832653

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WMDF-10-ENV / WMDF-10-ENV-SS

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS

Universal Health Group

PATIENT R LUATION

Patient Name: Redacted

Date: 8-9-10

Patient Complaints:

- [x] Neck Pain Type: 10/10
- [x] Mid Back Pain Type: Shoulder blades, sharp, 8/10
- [x] Low Back Pain Type: on/off 10/10
- [x] R Arm Numbness Pins/needles crampy
- [x] L Arm Numbness crampy
- [x] R Leg Numbness Pins/needles crampy
- [ ] L Leg Numbness
- [ ] Upper Extremity Weakness R L
- [x] Lower Extremity Weakness (R) L

- [x] Headaches Frequency: 3/wk
- [ ] Dizziness Frequency: Resolved
- [ ] Memory Loss Frequency:
- [ ] Tinnitus Frequency:
- [x] Jaw Pain Frequency:
- [ ] ~~Memory Loss~~
- [x] Trouble Sleeping
- [ ] Others:

Difficulty:

- [x] Sitting
- [x] Standing
- [x] Lifting
- [x] Bending
- [x] Pushing
- [x] Pulling
- [x] Reaching Overhead
- [x] Squatting
- [x] Kneeling
- [ ] Others:

Muscle Spasm:

- [x] Sub Occipitals
- [x] Cervical Spine Para Spinal
- [x] Thoracic Spine Para Spinal
- [x] Lumbar Spine Para Spinal
- [x] Traps
- [x] Levator Scapula
- [x] Quadratous Lumorum
- [ ] Piriformis
- [ ] Hamstrings

Palpation Cervical:

- [x] C1
- [x] C2
- [x] C3
- [x] C4
- [x] C5
- [x] C6
- [x] C7

Palpation Thoracic:

- [x] T1
- [x] T2
- [x] T3
- [ ] T4
- [x] T5
- [x] T6
- [x] T7
- [x] T8
- [x] T9
- [x] T10
- [ ] T11
- [ ] T12

Palpation Lumbar:

- [ ] L1
- [x] L2
- [x] L3
- [x] L4
- [x] L5
- [x] Sacrum
- [ ] Right Ileum
- [ ] Left Ileum

PHYSICAL EXAM

- [x] Neck Spasms (Y) N
- [x] Right
- [x] Left
- [x] Sub Occipitals Spasm
- [ ] Decreased Grip Strength R L
- [ ] Decreased Muscle Strength R L
- [x] Cervical Compression Test (+) -
- [x] Shoulder Depression Test (+) -
- [ ] Soto Hall Test + -
- [x] Valsalva's Test (+) -
- [x] Cervical Distraction Test (+) -

ROM : Pain = 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓ ↑	PAIN
FLEXION	↓	3
EXTENSION	↓	3
RIGHT LATERAL FLEXION	↓	3
LEFT LATERAL FLEXION	↓	3
RIGHT ROTATION	↓	3
LEFT ROTATION	↓	3

Physical Exam

- [x] Lumbar Spasms (Y) N
- [x] Right
- [x] Left
- [x] Decreased Muscle Strength (R) L
- [x] Straight Leg Raiser Right (+) -
- [x] Straight Leg Raiser Left (-) -
- [x] Braggard's Test (-) -
- [x] Kemps Test L (R) (-) -
- [x] Patrick Faber Test L (R) (-) -
- [ ] Other _____

ROM : Pain= 1 Minimal 2 Moderate 3 Severe Not tested unless indicated

	↓ ↑	PAIN
FLEXION	↓	3
EXTENSION	↓	3
RIGHT LATERAL FLEXION	↓	3
LEFT LASTERAL FLEXION	↓	3
RIGHT ROTATION	↓	3
LEFT ROTATION	↓	3

Pain

- [ ] Chest pain
- [ ] Abdominal Pain
- [x] Head Pain
- [ ] Elbow Pain R L
- [ ] Hand Pain R L
- [x] Leg Pain (R) L
- [ ] Knee Pain R L
- [ ] Ankle Pain R L
- [ ] Foot Pain R L
- [x] Others: Chest + Rib pain
- [ ] Others: _____

Testing / Consultations

- [x] Medical Doctor Dr. Chandler
- [x] MRI (+) C, T, L-Spine
- [ ] CT SCAN
- [x] EMG Set-up with Dr Tobe
- [x] CLOSED HEAD EVALUATION Set-up with Dr. Tobe
- [ ] IME
- [x] PHYSICAL THERAPY will set-up
- [x] HOSPITAL Henry Ford - Day of MVA
- [x] PAIN MANAGEMENT Dr. Reese
- [ ]
- [ ]
- [ ]
- [x] See Previous Re-Exam

Diagnosis

- [x] Cervical Sprain
- [x] Thoracic Sprain
- [x] Lumbar Sprain
- [x] Headaches
- [x] Cervical Radiculitis
- [x] Lumbar Radiculitis
- [x] Muscle Spasm(s)
- [ ] Joint Pain
- [x] Sleep disturbances

- [x] Cervical disc displacement
- [ ] Thoracic disc displacement
- [x] Lumbar disc displacement
- [x] Concussion
- [x] Lumbago
- [x] T-Spine pain
- [x] Chest / Rib pain
- [ ]
- [ ]

Re-Evaluation (continued) page 3

Treatment Plan

☐ Continue current treatment plan 3 times a week for 4 weeks.

☑ Moist Heat
☐ Ice
☑ Mechanical Traction
☑ Deep Tissue Massage Therapy 1/week
☐ Therapeutic Exercises Cervical Thoracic Lumbar
☑ Adjustments

Disability

☑ Work
☑ Household
☐ Attendant Care ____ times a week, for ___ hours a day
☑ Driving

Progress

☐ Excellent
☐ Good
☑ Guarded
☐ Poor
☑ Depend on further treatment
☐ Depend on further diagnostic testing
☐ _____

Goals

☑ Decrease Pain
☑ Increase Strength
☑ Increase Range of Motion
☑ Restore activities of daily living
☑ Initiation of Independent home exercise program
☑ Back to a full time work schedule

Discussion

1) Continue TX 3/week
2) Massage therapy 1/week
3) Follow up with Dr Chandler, Dr. Prince
4) Schedule Dr. Tolia - EMG, Closed Head Eval
5) Schedule PT

Physicians Signature: [signature] **Date:** 8-9-10

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
FAX 888-845-8680
PO BOX 2361
BLOOMINGTON IL 61702

CARRIER

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) — X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 22B143652

2. PATIENT'S NAME: Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: F X

4. INSURED'S NAME: Redacted

5. PATIENT'S ADDRESS: 6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES NO X

b. AUTO ACCIDENT? YES NO X PLACE (State)

c. OTHER ACCIDENT? YES NO X

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH SEX: Redacted M F X

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 08 09 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: FRANCISCO GUTIERREZ JR BS

17a.

17b. NPI 1700041365

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 7220 72210 72211 7231 7241 7242

20. OUTSIDE LAB? YES NO X $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 739 1
2. 739 2
3. 739 3
4. 739 4

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23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 09 10	08 09 10	11		99212		1234	150 00	1		NPI	1700041365
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 205918486 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 7420C9003

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 150 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
FRANCISCO GUTIERREZ
SIGNED: 08 12 10 DATE

32. SERVICE FACILITY LOCATION INFORMATION
UNIVERSAL HEALTH GROUP
25900 GREENFIELD RD #140
OAK PARK MI 48237
a. 1588832653 b.

33. BILLING PROVIDER INFO & PH. # (248) 8894580
UNIVERSAL HEALTH GROUP
5761 W MAPLE RD
WEST BLOOMFIELD MI 48322
a. 1588832653 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500OS

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DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

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I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

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DATE: 5/31/12 (11) DOA: 9-6-11

PATIENT NAME LAST: Redacted UniversalHealthGrou FIRST: Redacted DOB: 10-23-56

SUBJECTIVE: SEVERITY SCALE 1-10 (EXCRUCIATING) Type of complaint: L=left R=right W=weakness N=numbness T=tingling S=sharp A=achy D=dull B=burning C=constant F=frequent O=occasionally

4/10 NECK	ARM	LEG	ELBOW	HEADACHE	
3/10 MID BACK	SHOULDER	HIP	ANKLE	DIZZINESS	
6/10 LOW BACK	WRIST	KNEE	CHEST	MEMORY LOSS	
BUTTOCK	HAND	FOOT	ABDOMEN	SLEEP DIST.	

NOTES: [illegible]

OBJECTIVE: POSTURE/GAIT: (NORMAL) ABNORMAL NOTE:

PALPATION FINDINGS: L=left R=right T=tenderness S=spasm

L R (T) S Suboccipitals	L R (T) S Posterior Cervicals	L R (T) S Trapezius	L R (T) S Paraspinals
L R (T) S Erector Spinae	L R T S Quadratus Lumborum	L R T S Piriformis	L R T S Gluteal

NOTES:

ASSESSMENT: ☐ First visit ☐ Guarded ☒ Continue – no change ☐ As expected ☐ Exacerbation of condition
☐ Mild improvement ☐ Moderate improvement ☐ Other:

Adjustment: OCC/C1/C2/C3/C4/C5/C6/C7/T1/T2/T3/T4/T5/T6/T7/T8/T9/T10/T11/T12/L1/L2/L3/L4/L5/S/RSI/LSI

Extra Spinal: L/R shoulder L/R elbow L/R wrist L/R hand L/R knee L/R ankle foot Other:

NOTES: [illegible]

PROGRESS/TREATMENT PLAN: Goals: reduce symptoms, increase functional capacity and return to normal activities of daily living

☐ THERAPEUTIC PHASE 1: Acute inflammatory, reduce inflammation, muscle spasm and pain

☐ THERAPEUTIC PHASE 2: Repair and remobilization: functional scar formed and increase pain-free ROM

☒ THERAPEUTIC PHASE 3: Remodeling and rehab: increase coordination, strength, ROM, endurance and work capacity

Tx schedule: ☐ daily ☐ 3x/wk ☐ 2x/wk ☐ 1x/wk ☐ 2 wks ☐ 3 wks ☐ monthly ☒ cont. Tx plan Massage: ☐ 0 ☒ 1 ☐ 2 per wk/mo

NOTES:

SERVICES OR SUPPLIES RENDERED

Pt. Init.	NEW PATIENT EXAM
	99201---Brief
	99202---Limited
	99203---Moderate
	99204---Extensive
	99205---Comprehensive
	ESTABLISHED PATIENT EXAM
	99211---Brief
	99212---Limited
(W)	99213---Moderate
	99214---Extensive
	99215---Comprehensive

Pt. Init.	MODALITIES
	97010---Hot/Cold Pack
	97012---Mechanical Traction
	MANIPULATION TREATMENT
	98940---Adjust 1-2 regions
	98941---Adjust 3-4 regions
	98942---Adjust 5+ regions
	98943---Extraspinal
	THERAPEUTIC TREATMENT
	97110--Therapeutic exercise

Pt. Init.	X-RAY EXAMINATION
	72010---Full spine AP/Lateral
	72020---Single view
	72040---Cervical 2-3 views
	72050---Cervical 4 views
	72052---Cervical complete
	72070---Thoracic 2 views
	72100---Lumbar 2-3 views
	72110---Lumbar 4 views
	72120---Lumbar bending
	72170---Pelvic 1-2 views
	72202---Sacrum 3 views

Pt. Init.	MISCELLANEOUS SERVICES
	95999---Neurologic exam
	97760---Orthotic fitting
	99002---Orthotic mailing
	99080---Narrative report
	l0120---Cervical foam collar
	l0625---Lumbar support
	l3020---Foot insert molded
	e0100---Straight cane
	e0190---Position cushion/pillow
Type	Auto - S&F - WC - Reg - Cash

CPT CODE (98941): This is a manual spinal adjustment of up to 4 regions. Performed by hand (full spine), Thompson Drop Technique which the patient is adjusted by hand and the table drops from underneath the patient or Activator Technique in which a handheld instrument is used to adjust the patient. These adjustments remove vertebral fixations (subluxations) and realign the vertebrae of the spine.
CPT CODE (97010-59): Hot/Cold pack used to relax the tissue. It mobilizes edematous fluid, increased blood flow and reduces muscle spasms
CPT CODE (97012-59): Intersegmental Mechanical Traction. Each vertebra is tractioned out separately. This improves the biomechanics of the vertebral structure. In doing so it helps promote the return of the normal/natural spinal curvature.

Referred To/For:

DISCLOSURE AND ACKNOWLEDGEMENT

I attest to the fact that the above services were rendered and they were explained to me and I agree and give my complete informed consent to continue as the doctor feels necessary. I am aware my file is available for review upon my request.

[signature] D.C. [signature] [signature] SF 09112911

Treating physician: (print) and signature Patient/Guardian signature

CHIROPRACTIC DAILY TREATMENT SHEET - DETROIT

UniversalH...

Patient Name (last): Redacted First: Redacted Age: ____ ☒ Male ☐ Female

☐ Initial exam ☒ Re-exam
Height: ________ Weight: ________ lb
Blood Pressure: ________
Posture: ________
Gait: ________
Skin (bruising, scars): ________
Other: ________

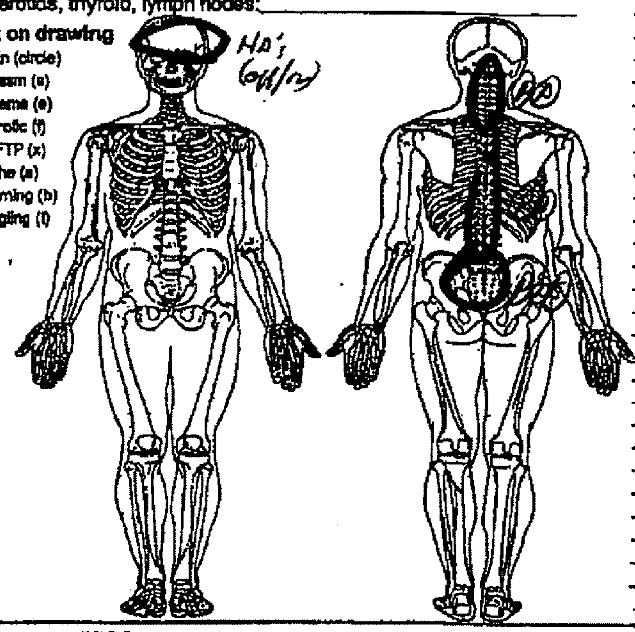
Sensation ☐ DNP	L	R
Light touch		
Sharp/dull		
Vibration		

Reflexes (0-5) ☐ DNP	L	R
Biceps (C5)(musculocutaneous)		
Brachioradialis (C6)(radial)		
Triceps (C7)(radial)		
Patellar (L4)(femoral)		
Medial hamstring(L5)(sciatic)		
Achilles (S1)(tibial)		
Babinski		
Other:		

CHI ☐ WNL	
☒ Headaches	☐ Dizzy
☐ Blurred vision	☒ Sleep disturbance
☐ Tinnitus	☒ Memory loss
☐ Nausea/vomiting	☐ Photosensitivity

Palpation: ☐ WNL
☐ Skin, temperature, moisture: ________
☐ Parotids, thyroid, lymph nodes: ________

Mark on drawing
☐ pain (circle)
☐ spasm (s)
☐ edema (e)
☐ fibrotic (f)
☐ MFTP (x)
☐ ache (a)
☐ burning (b)
☐ tingling (t)



Spinal Palpation
C0, C1, C2 (X), C3, C4 (X), C5 (X), C6, C7, T1, T2, T3, T4 (X), T5 (X), T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4 (X), L5 (X), S1 (X), Co, SI

Orthopedic exam: ☐ WNL, ☐ other: ________

Motor (0-5) ☐ DNP	L	R
Resisted neck ROM (C1-C4)	5	5
Shoulder elevation (CN XI, C3-C5)	↓	↓
Shoulder abduction (C4-C6)	↓	↓
Elbow flexion (C5-C6)	↓	↓
Elbow extension (C6-C8)	↓	↓
Wrist/finger flexion (C7-T1)	↓	↓
Wrist/finger extension (C6-C8)	↓	↓
Hip flexion (L1-L3)	↓	↓
Knee extension (L2-L4)	↓	↓
Knee flexion (L4-S1)	↓	↓
Plantar flexion (L5-S2)	↓	↓
Dorsiflexion (L4-L5)	↓	↓
Other:	—	—

Functional - DNP	+	-
Heel walk (L3, L4, L5)		
Toe walk (S1)		
Tandem Romberg		
Romberg		
Other:		

Cervical ☐ WNL	L	R
Compression	(+)	
Maximal compression	(+)	(+)
Distraction	(−)	
PROM		
Shoulder Depressor	(+)	(+)
Soto Hall/Brudzinski		
Flexion (45°)	WNL	
Extension (55°)	↓	↓
Lateral flexion (45°)	↓	↓
Rotation (70°)	↓	↓

(P)/tightness

Lumbar ☐ WNL	L	R
Kemp's test	(+)	(+)
SLR passive, active	(+)	(+)
Braggard's	(−)	(−)
Patrick's (FABERE)	(+)	(+)
Thomas/Gaenslen's	(+)	(+)
Valsalva		
SI distraction/compression	(+)	(+)
Flexion (90°)	WNL	(P)
Extension (30°)	↓	↓
Lateral flexion (20°)	↓	↓
Rotation (30°)	↓	↓

tenderness/tight

NOTES: Pt states s/t/c (P) with tightness in the (B) / [illegible] no. [illegible]
good. Pt had difficulty with ROM with (B) pt will cont. care (@)
2x wk for 2wks / or 1x wk for 2wks. Re-eval on 8/1/12.

Doctor: [signature] Doctor(printed): Scott A. Witinok DC Date: 5/31/12

SEP 03 2012

UHG-DET PHYSICAL EXAM U1

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

STATE FARM INSURANCE
PO BOX 661023
DALLAS TX 75266

CARRIER

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 118070161

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Redacted

3. PATIENT'S BIRTH DATE: Redacted SEX: [X] M [ ] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Redacted

5. PATIENT'S ADDRESS (No., Street): Redacted

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]
b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State) MI
c. OTHER ACCIDENT? YES [ ] NO [X]

10d. RESERVED FOR LOCAL USE

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM INSURANCE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06 01 12

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY: 09 06 11 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: SCOTT WITINKO DC

17a:

17b. NPI: 1447449905

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 72291 72292 72293 7241 7242 7231

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES: 0 00

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 739 1
2. 739 2
3. 739 3
4. 739 4

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 31 12	05 31 12	11		99213		1234	200 00	1		NPI	1447449905
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 205918486 [X]

26. PATIENT'S ACCOUNT NO.: 39630C98476

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 200 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 200 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SCOTT WITINKO DC
SIGNED 06 05 12 DATE

32. SERVICE FACILITY LOCATION INFORMATION
UNIVERSAL HEALTH GROUP
2888 W GRAND BLVD
DETROIT MI 48202-2612
1588832653 b

33. BILLING PROVIDER INFO & PH. # (248)8894580
UNIVERSAL HEALTH GROUP
2000 TOWN CENTER SUITE 625
SOUTHFIELD MI 48075-1135
a. 1588832653 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

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